AUTHORIZATION FOR
AUTHORIZED REPRESENTATIVE TO ACCESS
Fremont Health's My Health Record

My Health Record is an electronic tool that offers patients personalized access to portions of their medical records. It enables them to securely use the Internet to help manage and receive information about their health care.

Patients may grant authorized representatives access to their My Health Record account. The authorized representative will be able to view and manage information in the patient's My Health Record account, including any information provided through the patient's medical health record and information added by the patient. This could include information relating to substance abuse (including alcohol/drug abuse), mental health, and HIV/AIDS related information (including test results).

PATIENT NAME ____ **DOB**______________________

ADDRESS____ **PHONE #** _________________

CITY ____________________________________ **STATE** __________________ **ZIP** ________________

EMAIL ADDRESS____

This authorization is given at my request.
I hereby designate the following individual as an authorized representative for the purpose of accessing my My Health Record account:

AUTHORIZED REPRESENTATIVE

Name ____ DOB ____________________

Address ____

E-Mail Address ____

Relationship to Me____ Phone #_________________

I hereby authorize the Health Information Department at Fremont Health to grant access to my My Health Record account to the authorized representative identified above.

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Fremont Health.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.
3. This authorization is effective until my death, unless earlier revoked by me. I understand that I may revoke this authorization at any time by giving written notice to the Health Information Department at Fremont Health. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

____ ___________________________
Signature of Patient or Patient's Personal Representative Date